STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155272	B. WIN			03/09/2	011
NAME OF I	PROVIDER OR SUPPLIER	,	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SULLER				82ND ST		
KINDREI	D TRANSITIONAL (CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0000	This visit was for	r Investigation of	F00	00	To Whom It May Concern:Plea	as	
	Complaints IN00	0086031 and			accept the following Plan of		
	IN00086609.				Correction related to the surve completed March 9,2011. We		
					request a desk		
	Complaint IN000	086031- Substantiated			review.Thanks,Matt		
	Federal/State def	ficiencies related to the			WyssExecutive Director		
	allegations are ci	ited at F246 and F253.					
	Complaint IN000	086609- Substantiated					
	with no deficient	cies related to the					
	allegations cited.						
	Survey dates: Ma	arch 8, 9 2011					
	Facility number:						
	Provider number						
	AIM number: 10	00267130					
	Comments to a man						
	Survey team: Chuck Stevensor	n DN					
	CHUCK SIEVEHSOI	II, IXIV					
	Census bed type:						
	SNF/NF: 142	•					
	Total: 142						
	10111. 172						
	Census payor typ	pe:					
	Medicare: 37	i.					
	Medicaid: 79						
	Other: 26						
	Total: 142						
	Sample: 5						
	•						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TBIF11

Facility ID:

000172

If continuation sheet

I	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272					E SURVEY PLETED (2011
	PROVIDER OR SUPPLIER	CARE AND REHAB-CASTLETON	5226 E	ADDRESS, CITY, STATE, ZIP CO 82ND ST NAPOLIS, IN46250	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	findings cited in 16.2.	es also reflect State accordance with 410 IAC ompleted on March 14, alkner, RN				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	ETED	
		155272	B. WING 03/		03/09/2	03/09/2011	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				82ND ST		
KINDRE	TRANSITIONAL C	CARE AND REHAB-CASTLETON			APOLIS, IN46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0246	Based on record	review and interview, the	F024	46	This serves as the Allegation of	of	03/28/2011
SS=E	facility failed to	provide a comfortable			Compliance for Kindred		
	environment by i	not providing an adequate			Transitional Care & Rehabilitate Center-Castleton for the recen		
		ter for comfortable			complaint survey dated 03/09/		
		onal care for 4 residents			Kindred Transitional Care &		
		dents C and F in room			Rehabilitation Center-Castleto	n	
		and E in room 235) of 4			asserts that all corrections		
	*	,			described on this Plan of		
		ed for comfortable water			Correction have been		
	-	potentially affected			implemented. In regards to the	е	
	population of 142	2.			specific deficiencies, we have outlined our corrective actions		
					and continued interventions to		
	Findings include				assure compliance with		
					regulations and our plan of act	tion.	
	1. An undated fa	icility document titled			The staff of Kindred Transition	al	
		ures" provided by the			Care & Rehabilitation		
	•	ector on 3/09/11 at 2:30			Center-Castleton is committed		
					delivering high quality health c to its residents to obtain their	are	
	-	ed to be the facility's			highest level of physical, ment	al	
	-	ecking and recording			and psychosocial functioning.		
	water temperatur	es indicated:			respectfully submit Kindred		
					Transitional Care & Rehabilita	tion	
	"Water Temperat	ures:Measure water			Center-Castleton is in substan		
	temperature rand	omly and record			compliance as set forth below,		
	sameIdeal temp	perature is 110 to 120			are confident that it will be four	nd	
	Degrees"				in substantial compliance with regulations upon re-survey.	he	
					statements made on the plan		
	2. The record of	Resident C was			correction are not an admissio		
	reviewed on 3/09				to and do not constitute an		
	10 viewed oii 3/05	7/11 at 2.10 p.m.			agreement with the alleged		
	D:				deficiencies herein. F246 The		
	•	led, but were not limited			Resident has the right to resident has the right to reside		
	, 1 1 0	ebility, and a history of			and receive services in the fact with reasonable accommodation	-	
	bilateral above th	ne knee amputations.			of individual needs and	0.10	
					preferences, except when the		
	An admission M	inimum Data Set			health or safety of the individu	al	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155272	B. WIN			03/09/2	011
		II.	D. (111)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹			82ND ST		
KINDRE	D TRANSITIONAL (CARE AND REHAB-CASTLETON			APOLIS, IN46250		
(X4) ID		STATEMENT OF DEFICIENCIES	_	ID	,		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
0		ment,t dated 2/04/1,1	+		or other residents would be		Dille
	, ,	ent C had no cognitive or			endangered. I. How correctiv	е	
					action will be accomplished for	r	
		deficits, was bed bound,			those affected. Residents C,D		
	_	ff assistance for all			& F will be offered bed bath wa		
	activities of dail	y living.			that is comfortable for them.	l.	
					How corrective action will be accomplished for those reside	nte	
	A review of nurs	se's notes from admission			having potential to be affected		
	to 3/09/1,1 indic	ated Resident C was alert,			The Maintenance Supervisor		
	oriented, and ab	le to make his wants and			designee will make random da	ily	
	needs known.				water temperature round audit		
					Resident and shower rooms to)	
	Resident C was	interviewed on 3/09/11 at			assure the Facility water		
					temperatures are within a safe and comfortable range. The	;	
	1	gain on 3/09/11 at 1:40			Maintenance Supervisor or		
	1 ^	ed that when he received			designee will review findings w	vith	
		ter was "often-at least			the Administrator weekly and		
	once a week" to	o cool for comfort. He			corrective action will be		
	indicated that w	nen he told the aide this,			implemented as indicated. III.		
	she indicated "th	at's as warm as it's going			What measures will be put in		
	to get."				place/systemic changes made		
					ensure correction. The SDC of designee will inservice CNA's		
	3 The record of	Resident D was reviewed			bed bathing procedure. This	011	
	on 3/09/11 at 10				training will include water		
	011 3/0 3/11 at 10	.43 a.m.			temperature preference for		
	Diameter in 1	dad had aren net the test			bedside Resident bathing. Th		
	1	ded, but were not limited			SDC or designee will inserivce		
	1	, coronary artery disease,			CNA's on completion of bed ba	ath	
	and multiple scl	erosis.			procedures during general orientation. IV. How the facili	tv.	
					plans to monitor its performan	•	
	A review of nurs	se's notes from admission			to make sure those solutions a		
	to 3/09/11 indica	ated Resident D was alert,			sustained. The Maintenance		
	oriented, and abl	le to make her wants and			Supervisor will monitor througl	า	
	needs known.				environmental rounds on a	. ,	
					random daily basis to assure t		
	Resident Days	interviewed on 3/09/11 at			the facility's water temperature are maintained between 110 to		
	Resident D was	interviewed on 3/03/11 at			are maintained between 110 to	,	
			1				

Facility ID:

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPLI	
AND PLAIN	OF CORRECTION	155272	1	ILDING		03/09/20	
		100272	B. WIN		A PROPERTY OF THE CARE	00/00/20	711
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 82ND ST		
KINDREI	D TRANSITIONAL (CARE AND REHAB-CASTLETON			APOLIS, IN46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION DATE
IAG		gain on 3/09/11 at 1:45	+	IAG	120 degrees Fahrenheit. The		DAIE
		ed she was able to			data will be reviewed monthly	for	
	1 ^	oathroom and take care of			3 months and then quarterly a		
		ds. She stated "There's			the Performance Improvement Committee Meeting. The	t	
	_	t water. It's lukewarm all			Administrator is responsible fo	r	
		nem but they don't do			the overall compliance. Resid	ent	
		as unable to recall who			Council meetings held monthly will be used to monitor	/	
	•	at this problem. She			performance. V. Completion		
		ukewarm water for care			Date: 3/28/2011		
	was uncomfortab	ole.					
	4 The record of	Resident E was reviewed					
	on 3/09/11 at 11:						
	Diagnoses includ	led, but were not limited					
	to, a history of co	erebral vascular accident					
	(stroke), hyperter	nsion, and diabetes					
	mellitus.						
		e's notes from admission					
		ted Resident E was alert,					
	i i	e to make her wants and					
	needs known.						
	Resident E was i	nterviewed on 3/09/11 at					
		gain on 3/09/11 at 1:45					
		ed she was able to					
	l *	oathroom and take care of					
	her personal need	ds. She stated, "The water					
	in the bathroom	is always cool. There's					
	never really hot	water." She indicated					
	· ·	water for care was					
	"unpleasant.".						

PRINTED: 03/31/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				IULTIPLE COI ILDING	NSTRUCTION	(X3) DATE S	ETED
		155272	B. WIN			03/09/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-CASTLETON	1	1	82ND ST APOLIS, IN46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	5. The record of 3 on 3/09/11 at 2:3	Resident F was reviewed 0 p.m.					
	"	led, but were not limited					
	to, diabetes melli	itus, parapiegia, iistory of multiple					
		nd bilateral above the					
	knee amputations						
	1						
	A review of nurse	e's notes from admission					
	to 3/09/1,1 indica	ated Resident E was alert,					
	· ·	e to make his wants and					
	needs known.						
	Resident F was in	nterviewed on 3/09/11 at					
		icated he was bed bound					
	_	ff to give him bed baths.					
	He indicated the	water used for his bath					
		or warm at best." He					
		he received his bath early					
		by 6:00 or 6:30 or so" the					
		not, but "if it's after 11:00					
		g to be cold." Resident F n bath helped him "feel					
	better all over."	i oam neipea mm i ieei					
	This Federal tag	relates to Complaint					
	IN00086031.						
	3.1-3(v)(1)						

000172

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155272		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION		E SURVEY PLETED 2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON		5226 E INDIAN	ADDRESS, CITY, STATE, ZIP CODE 82ND ST IAPOLIS, IN46250	•		
	O TRANSITIONAL O SUMMARY S (EACH DEFICIEN		5226 E	82ND ST	ION D BE	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S	ETED
		155272	B. WING	G		03/09/2011	
	PROVIDER OR SUPPLIER TRANSITIONAL C	CARE AND REHAB-CASTLETON		5226 E	ADDRESS, CITY, STATE, ZIP CODE 82ND ST IAPOLIS, IN46250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F0253 SS=E	interview, the factomfortable environment and adequate suppression degrees or greater rooms with water below 110 degrees and failed to prove temperatures for (Residents C and Residents D and residents interview water temperature affected populations.) 1. An undated factor water Temperature Maintenance Direpton. and indicate procedure for chewater temperature rand sameIdeal temperature rand sameIdeal temperature rand sameIdeal temporature rand same same same same same same same same	acility document titled ures" provided by the ector on 3/09/11 at 2:30 and to be the facility's ecking and recording es indicated:	F02:	53	This serves as the Allegation of Compliance for Kindred Transitional Care & Rehabilitation Center-Castleton for the recencomplaint survey dated 03/09/Kindred Transitional Care & Rehabilitation Center-Castleton asserts that all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of act The staff of Kindred Transitions Care & Rehabilitation Center-Castleton is committed delivering high quality health of to its residents to obtain their highest level of physical, ment and psychosocial functioning respectfully submit Kindred Transitional Care & Rehabilitation Center-Castleton is in substant compliance as set forth below, are confident that it will be four in substantial compliance with regulations upon re-survey. The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. F253The Resident has the right to reside and receive services in the fact with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual needs and preferences, except when the health or safety of the individual needs and preferences, except when the health or safety of the individual needs and preferences, except when the health or safety of the individual needs and preferences, except when the health or safety of the individual needs and preferences, except when the health or safety of the individual needs and preferences.	tion t 11. n e ion. al to are al, We tion tial we nd he of n	03/28/2011
					!		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ((X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLE			COMPLETED
		155272	B. WIN			03/09/2011
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				82ND ST	
KINDREI	O TRANSITIONAL C	CARE AND REHAB-CASTLETON			IAPOLIS, IN46250	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE
	a maximum susta	ained hot water			or other residents would be	
	temperature of 10	02 degrees. Both the			endangered. I. How corrective	
	Administrator an	d Maintenance Director			action will be accomplished fo those affected. Residents C,D	
	indicated the mir	nimum hot water			& F will be offered bed bath wa	
		ild be 110 degrees. Two			that is comfortable for them. I	
	residents resided	•			How corrective action will be	
	residents resided	in each room.			accomplished for those reside	nts
	0.751				having potential to be affected	
		Resident C was reviewed			The Maintenance Supervisor	
	on 3/09/11 at 2:1	0 p.m.			designee will make random da	
					water temperature round audit Resident and shower rooms to	
	Diagnoses includ	led, but were not limited			assure the Facility water	'
	to, paraplegia, de	ebility, and a history of			temperatures are within a safe	,
	bilateral above th	ne knee amputations.			and comfortable range. The	
		F			Maintenance Supervisor or	
	An admission M	inimum Data Set			designee will review findings v	vith
					the Administrator weekly and	
	` ′	nent,t dated 2/04/11,			corrective action will be	
		nt C had no cognitive or			implemented as indicated. III. What measures will be put in	
		deficits, was bed bound,			place/systemic changes made	s to
	and required staf	f assistance for all			ensure correction. The SDC o	
	activities of daily	living.			designee will inservice CNA's	
					bed bathing procedure. This	
	A review of nurs	e's notes from admission			training will include water	
		ated Resident C was alert,			temperature preference for	
	· ·	e to make his wants and			bedside Resident bathing. Th	ı
	needs known.	o to make me wants and			SDC or designee will inserivee CNA's on completion of bed ba	
	necus kiiuwii.				procedures during general	uui
	D: 1 (C				orientation. IV. How the facili	ty
		nterviewed on 3/09/11 at			plans to monitor its performan	- 1
		gain on 3/09/11 at 1:40			to make sure those solutions a	are
	p.m. He indicated that when he received				sustained. The Maintenance	
	bed baths the water was "often-at least				Supervisor will monitor through	h
	once a week" too cool for comfort. He				environmental rounds on a	hat
	indicated that wh	en he told the aide this,			random daily basis to assure the facility's water temperature	
		at's as warm as it's going			are maintained between 110 to	ı
	til					
						l

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155272	B. WINC			03/09/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				82ND ST		
KINDREI	O TRANSITIONAL O	CARE AND REHAB-CASTLETON			APOLIS, IN46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Ι.	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	to get."				120 degrees Fahrenheit. The		
					data will be reviewed monthly		
	4. The record of	Resident D was			3 months and then quarterly a		
		9/11 at 10:45 a.m.			the Performance Improvement	·	
	l reviewed on 3/0/	7/11 at 10.43 a.m.			Committee Meeting. The Administrator is responsible fo	<u> </u>	
	D	1.1.1.7			the overall compliance. Resid		
	_	led, but were not limited			Council meetings held monthly		
		coronary artery disease,			will be used to monitor		
	and multiple scle	erosis.			performance. V. Completion		
					Date: 3/28/2011		
	A review of nurs	e's notes from admission					
	to 3/09/11, indica	ated Resident D was alert,					
	oriented, and abl	e to make her wants and					
	needs known.						
	110000 11110 ((111						
	Pagidant Dayag i	interviewed on 3/09/11 at					
	_	gain on 3/09/11 at 1:45					
	•	ed she was able to					
		oathroom and take care of					
	her personal need	ds. She stated "There's					
	never enough ho	t water. It's lukewarm all					
	the time. I told th	nem but they don't do					
		vas unable to recall who					
		at this problem. She					
		ukewarm water for care					
	was uncomfortab						
	was unconnoctat	JIC.					l
		PD 11 4E 1					
		Resident E was reviewed					
	on 3/09/11 at 11:	30 a.m.					
	Diagnoses includ	led, but were not limited					l
	to, a history of ce	erebral vascular accident					l
	_	nsion, and diabetes					l
	mellitus.	,					

000172

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON (NA) ID SUMMARY STATEMENT OF DEFICIENCIES (IACALI DEFICURY MIST III PERCIDID BY TRUI.) TAG A review of nurse's notes from admission to 3/09/11 at 1.45 p.m. She indicated she was able to ambulate to the bathroom and take care of her personal needs. She stated "The water in the bathroom is always cool. There's never really hot water." She indicated was "unpleasant." 6. The record of Resident F was reviewed on 3/09/11 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, paraplegia, hypertension, a history of multiple pressure sores, and bilateral above the knee amputations. A review of nurse's notes from admission to 3/09/11 at 0.309/11 indicated Resident F was reviewed on 3/09/11 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, paraplegia, hypertension, a history of multiple pressure sores, and bilateral above the knee amputations. A review of nurse's notes from admission to 3/09/11 indicated Resident E was alert, oriented, and able to make his wants and needs known. Resident F was interviewed on 3/09/11 at 2:30 p.m.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON (X4) ID SUMMARY STATEMENT OF DEPICIENCES (CAS) REFERENCE OF STATEMENT OF DEPICIENCES (CAS) REGISTRANSITIONAL CARE AND REHAB-CASTLETON REGILATORY OR LSC IDENTIFYING INFORMATION) A review of nurse's notes from admission to 3/09/11, indicated Resident E was alert, oriented, and able to make her wants and needs known. Resident E was interviewed on 3/09/11 at 1:45 p.m. She indicated she was able to ambulate to the bathroom and take care of her personal needs. She stated "The water in the bathroom is always cool." There's never really hot water." She indicated using lukewarm water for care was "unpleasant." 6. The record of Resident F was reviewed on 3/09/11 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, paraplegia, hypertension, a history of multiple pressure sores, and bilateral above the knee amputations. A review of nurse's notes from admission to 3/09/11 indicated Resident E was alert, oriented, and able to make his wants and needs known.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а вілі	LDING		COMPL	ETED
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY TILL TAG (EACH DEFICIENCY MUST TAG (EACH DEFICIENCY MUST BE PERCEDED BY TILL TAG (EACH DEFICIENC			155272	1			03/09/2	011
SUMMARY STATEMENT OF DEFICIENCES INDIANAPOLIS, IN46250						ADDRESS, CITY, STATE, ZIP CODE		
INDIANAPOLIS, IN46250 INDI	NAME OF P	PROVIDER OR SUPPLIER			5226 E	82ND ST		
PREFIX TAG RESCHENCY MUST BE PERCEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) A review of nurse's notes from admission to 3/09/11, indicated Resident E was alert, oriented, and able to make her wants and needs known. Resident E was interviewed on 3/09/11 at 1-45 p.m. She indicated she was able to ambulate to the bathroom and take care of her personal needs. She stated "The water in the bathroom is always cool. There's never really hot water." She indicated using lukewarm water for care was "unpleasant." 6. The record of Resident F was reviewed on 3/09/11 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, paraplegia, hypertension, a history of multiple pressure sores, and bilateral above the knee amputations. A review of nurse's notes from admission to 3/09/11 indicated Resident E was alert, oriented, and able to make his wants and needs known.	KINDREI	O TRANSITIONAL C	CARE AND REHAB-CASTLETON					
A review of nurse's notes from admission to 3/09/11, indicated Resident E was alert, oriented, and able to make her wants and needs known. Resident E was interviewed on 3/09/11 at 9:00 a.m., and again on 3/09/11 at 1:45 p.m. She indicated she was able to ambulate to the bathroom and take care of her personal needs. She stated "The water in the bathroom is always cool. There's never really hot water." She indicated using lukewarm water for care was "unpleasant.". 6. The record of Resident F was reviewed on 3/09/11 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, paraplegia, hypertension, a history of multiple pressure sores, and bilateral above the knce amputations. A review of nurse's notes from admission to 3/09/11 indicated Resident E was alert, oriented, and able to make his wants and needs known.								(X5)
A review of nurse's notes from admission to 3/09/11, indicated Resident E was alert, oriented, and able to make her wants and needs known. Resident E was interviewed on 3/09/11 at 9:00 a.m., and again on 3/09/11 at 1:45 p.m. She indicated she was able to ambulate to the bathroom and take care of her personal needs. She stated "The water in the bathroom is always cool. There's never really hot water." She indicated using lukewarm water for care was "unpleasant.". 6. The record of Resident F was reviewed on 3/09/11 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, paraplegia, hypertension, a history of multiple pressure sores, and bilateral above the knee amputations. A review of nurse's notes from admission to 3/09/11 indicated Resident E was alert, oriented, and able to make his wants and needs known.		(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIA	ATE	
to 3/09/11, indicated Resident E was alert, oriented, and able to make her wants and needs known. Resident E was interviewed on 3/09/11 at 9:00 a.m., and again on 3/09/11 at 1:45 p.m. She indicated she was able to ambulate to the bathroom and take care of her personal needs. She stated "The water in the bathroom is always cool. There's never really hot water." She indicated using lukewarm water for care was "unpleasant.". 6. The record of Resident F was reviewed on 3/09/11 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, paraplegia, hypertension, a history of multiple pressure sores, and bilateral above the knee amputations. A review of nurse's notes from admission to 3/09/11 indicated Resident E was alert, oriented, and able to make his wants and needs known.	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
1:40 p.m. He indicated he was bed bound and relied on staff to give him bed baths.		A review of nurse to 3/09/11, indicated and able needs known. Resident E was it 9:00 a.m., and agp.m. She indicated ambulate to the behavior really hot with the bathroom in never really hot wising lukewarm to 3/09/11 at 2:3 Diagnoses include to, diabetes mellicular hypertension, a hypersure sores, and knee amputations. A review of nurse to 3/09/11 indicated oriented, and able needs known. Resident F was it 1:40 p.m. He incompleted.	e's notes from admission ated Resident E was alert, e to make her wants and enterviewed on 3/09/11 at again on 3/09/11 at 1:45 and she was able to bathroom and take care of each ds. She stated "The water is always cool. There's water." She indicated water for care was Resident F was reviewed 0 p.m. Ided, but were not limited attus, paraplegia, anistory of multiple and bilateral above the st. e's notes from admission ated Resident E was alert, e to make his wants and enterviewed on 3/09/11 at dicated he was bed bound					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/09/2011	
	PROVIDER OR SUPPLIER		STREET A 5226 E	ADDRESS, CITY, STATE, ZIP CODE 82ND ST IAPOLIS, IN46250			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
	was often "cool of indicated that if I in the morning, " water would be It or 11:30 it's goin indicated a warm better all over."	water used for his bath or warm at best." He he received his bath early by 6:00 or 6:30 or so" the not, but "if it's after 11:00 g to be cold." Resident F he bath helped him "feel relates to complaint					